PRINTED: 07/27/2012

From: acceptable

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			& MEDICAID SERVICES			FORM APPR OMB NO. 0938	
MANE OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF EAST RIDGE SIMMARY STATEMENT OF DEFICIENCES FRACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR ISC IDENTIFYING INFORMATION) F 323 483,25(h) FREE OF ACCIDENT The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place as recommended for one resident #1 was admitted to the facility on June 20, 2012, with diagnoses including history of Carciovascular Accident (Stroky with left-sided Hermparesis; Psychotic Disorder Mood Disorder due to General Medical Condition; Peripheral Vascular Disease (PVD), and Right Foot Transmetatarsal Amputation (TMA) Medical record review of a Fail Risk Evaluation dated June 2, 2012, revealed, a resident wno scores ten or nigher is at risk (of fails); the resident scored fourteen. Medical record review of a Care Plan Intervention dated June 26, 2012, revealed, "Gyrin mats placed on both sides of the bed and foot of the bed." STREET ADDRESS. CITY, STATE, ZIP CODE 1530 FINCHER AVENUE EAST RIDGE, TN 37412 PREPRIX FACAL OGRRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEACH CATOR SHOULD BE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING		(X3) DATE SURVEY COMPLETED C	
INTERCAPE CENTER OF EAST RIDGE TAG PREFIX EACH DEFIGIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) FREQULATORY OR ISC IDENTIFYING INFORMATION) FREQULATORY OR ISC IDENTIFYING INFORMATION) FREQULATORY OR ISC IDENTIFYING INFORMATION) FREGULATORY OR ISC IDENTIFYING INFORMATION) FREFIX [EACH DEFICIENCE TO SOME INFORMATION] FREGULATORY OR ISC IDENTIFYING INFORMATION) FREGULATORY OR ISC IDENTIFYING INFORMATION FREGULATORY OR ISC IDENTIFYING INFORMATION) FREGULATORY OR ISC IDENTIFYING INFORMATION FREGULATORY OR ISC IDENTIFY INFORMATION FREGULATORY OR ISC IDENTIFY I	oc #	10 # 2					
ILIFE CARE CENTER OF EAST RIDGE (743) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES REGILATORY ONLY MUST BE PRECEDED BY FULL REGILATORY ONLY MUST BE PRECEDED BY FULL REGILATORY ONLY ONLY DELY MUST BE PRECEDED BY FULL REGILATORY MUST BE PRE	NAME OF P	ROVIDER OR SUPPLIER					
### REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PROPERTY PREFIX TAG PREFIX TAG PROPERTY PROPERTY PREFIX TAG PROPERTY PROPE	LIFE CAF	RE CENTER OF EAS	TRIDGE	l l			
The facility must ensure that the resident environment remains as free of accident hazards as its possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place as recommended for one resident #1 was admitted to the facility on June 20, 2012, with diagnoses including history of Cardiovascular Accident (Stroke) with left-sided Hemiparesis; Psychotic Disorder Mood Disorder due to General Medical Condition: Peripheral Vascular Disease (PVD); and Right Foot Transmetatarsal Amputation (TMA). Medical record review of a Fall Risk Evaluation dated June 2, 2012, revealed a resident who scores ten or higher is at risk (of fails); the resident second fourteen. Medical record review of a Care Plan Intervention dated June 26, 2012, revealed. "Gym mats placed on both sides of the bed and foot of the bed." This plan of correction is submitted and required under Federal and State regulations and statutes applicable to long term care providers. The plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan of correction does not constitute an admission of liability on the part of the facility on the part of the facility and such liability is hereby specifically denied. The submission of this plan of correction does not constitute an admission of liability and used liability on the part of the facility and such liability is hereby	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE COM	PLETION
bed." ensure gym mats in place as ordered, and all were		The facility must e environment rema as is possible, and adequate supervision prevent accidents. This REQUIREMED by: Based on medical and interview, the device was in place resident (#1) of five The findings included and findings inclu	existion/Devices Insure that the resident ins as free of accident hazards I each resident receives ion and assistance devices to ENT is not met as evidenced I record review, observation, facility failed to ensure a safety re as recommended for one re residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one re residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one re residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one re residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one re residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one residents reviewed. I record review, observation, facility failed to ensure a safety re as recommended for one residents reviewed. I record review, observation, facility failed to ensure a safety reas recommended for one residents reviewed.	F 323	This plan of correction is submitted and required under Federal and State regulations and statutes applicable to long term care providers. The plan correction does not constitute an admission o liability on the part of the facility and such liability hereby specifically denied. The submission of this pl of correction does not constitute agreement by t facility that the surveyor' findings or conclusions at accurate, that the findings constitute a deficiency, of that the scope or severity regarding any of the deficiencies cited is correctly applied. 1. Resident #1 had additional gym mats placed at right side and foot of bed by nursing staff on 7/23/201 2. All other residents with gym mat orders were audited on 7/24/12 by	f is i. an he s re s	9/12
		• •	des of the dea and foot of the		ensure gym mats in place as ordered, and all were	,	

my deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sateguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued inogram participation.

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VES911

Facility ID: TN3308

If continuation sheet Page 1 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/27/2012 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
445296		B. WING	C 07/25/2012	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD	DE	
LIFE CARE CENTER OF EAST	RIDGE	. 1500 FINCHER AVENUE EAST RIDGE, TN 37412		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
order dated July 6, to floor while pt (partition of the room, on July 23, 2 the resident was ly observation reveals the floor, directly be the bed. Continue of the Director of Nonly one gym matabaside the resident interview with the I p.m., in the Confergym mats were to at the foot of the resident mats were in place and at the foot of the f	ew of a Physician's Telephone 2012, revealed, "Gym mats tient) is in bed" resident, in the resident's 2012, at 2:20 p.m., confirmed ing on the bed. Continued ed only one gym mat was on eside the resident's left side of diobservation, in the presence lursing, at 4:00 p.m., revealed was on the floor, directly t's left side of the bed. Director of Nursing at 4:05 rence Room, confirmed the be in place on both sides and esident's bed. Continued at the facility failed to ensure a on the resident's right side	F 323 An educational in-service was conducted on 8/2/1 by the Director of Nursion designee for the staff regarding the importance ensuring gym mats are place correctly and observed daily. Nursing administration conduct random gym maduits for four weeks at then monthly for four months, to determine proper application of gymats is being followed. Director of Nursing and Administrator will be notified of the audit findings weekly to ensure compliance. 4. The Director of Nursin	2 ing ing we of in will nat nd	
C/O #30075		designee will report observation results to t Quality Assurance Committee (consisting Medical Director, Dire of Nursing, Administra Social Services Directo Pharmacist and other interdisciplinary team members) monthly for months for further recommendations if needed. The Administra will monitor to ensure	ne of cetor ator, or, four	